

Surety Company Information**Bond No.** _____**HHA Name** _____**Medicaid Provider No.** _____*Home Health Agency Medicaid Bond*

KNOW ALL PERSONS BY THESE PRESENTS that subject to the terms, conditions and limitations of this Bond, _____, as Principal and, _____, a corporation organized and existing under the laws of the State of _____, as Surety, are held and firmly bound unto the DEPARTMENT OF HEALTH, an agency of the State of UTAH as Oblige, in the Penal Sum of \$ _____ for the payment of which Principal and Surety bind

_____ themselves, their heirs, executors, administrators and assigns, jointly and severally, by these presents.

WHEREAS, Principal desires to act as a Home Health Agency pursuant to the Medicaid program of said State; and

WHEREAS, the Secretary of the Department of Health and Human Services, pursuant to the Balanced Budget Act of 1997 and other applicable laws or regulations, requires that Principal provide a surety bond to Oblige as a condition of Federal Financial Reimbursement to Oblige for all or part of the cost of home health services furnished by Principal under the Medicaid program;

NOW THEREFORE, the condition of this Bond is that if the Principal shall pay to Oblige any and all unpaid Medicaid overpayments (as that term is defined below) then this Bond shall be null and void, otherwise to remain in full force and effect subject, however, to the following:

1. The term of this Bond shall be from the first day of January 1998 to and including the 31st day of DECEMBER 1998.
2. The Principal and Surety are liable under this Bond for only uncollected Medicaid overpayments (as defined in 42 C.F.R. §441.16(a)), for home health services which both become "uncollected" and for which Oblige first makes written demand for payment from the Surety, during the term of this Bond.
3. The Oblige or its designated agent shall promptly notify the Surety of any overpayment which it asserts against the Principal during the term of this Bond. Such notification shall be effective if sent by mail to the following address:

Surety Name

Street or PO Box Number

City, State Zip

4. The total aggregate maximum liability of the Surety under this Bond, including interest, is the Penal Sum stated above without regard to the number or amount of uncollected Medicaid overpayments. The surety will guarantee this amount for recovery of uncollected funds identified within two (2) years of the termination date of this bond.
5. The additional requirements set forth in 42 C.F.R. § 441.16(h) are hereby incorporated by reference and are binding on the Principal and Surety to the same extent as if set out verbatim herein.
6. Obligee is the sole obligee of this Bond, and no action may be brought on it by, or for the use or benefit of any person or entity other than Obligee or its designated agent.
7. The Principal or Surety may terminate or limit the scope or term of this bond only if the Surety furnishes Obligee with notice of such termination or limitation not later than: (a) if such termination or limitation is undertaken by the Principal, thirty (30) days after the Surety's receipt of notice of such termination or limitation; or (b) if such termination or limitation is undertaken by the Surety, sixty (60) days before the effective date of such termination or limitation.
8. This Bond is being submitted in compliance with § 441.16 of Title 42 of the Code of Federal Regulations as published in the Federal Register on January 5, 1998, as amended. This Bond is given to comply with and shall be interpreted under any and all such amended regulations.

IN WITNESS WHEREOF, the undersigned Principal and Surety have set their hands and seals on this _____ day of _____, 1998, but effective as of January 1, 1998.

PRINCIPAL (seal)

Name of Principal

By:

Typed Name and Title of Signator

SURETY (seal)

Name of Surety

By:

Typed Name and Title of Signator

*ATTACH THE POWER OF ATTORNEY OF THE SURETY'S
ATTORNEY-IN-FACT WHO EXECUTES THIS BOND.*

